South Carolina Workers' Compensation Commission
1612 Marion St. • P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___ - ___ - ____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - Work Phone: ( ) - Insurance Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) -

Compensation Paid:		Number of Weeks	From	To	Amount
1.	Number of Weeks T.T.				$
2.	Number of Weeks T.P.				$
3.	Number of Weeks P.P.				$
4.	Disfigurement				$
5.	Agreement and Final Release				$
	Total Compensation Paid				$
6.	Total Medical Benefits* Paid				$
7.	Funeral Benefits				$

☐ Case Denied

Date of Injury: _____
month day year

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____ By: _____ _____
Claimant Employer's Representative Date

_____
Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of Additional Fees and Recoupment

A.	Carrier Reimbursement by Third Party	$
B.	Attorney's Fee Paid by Employer	$
C.	Attorney's Fee Paid by Claimant (Non-contingent fees only)	$

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. * Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.